TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
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# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
Mark Hanson, D.C.

**Respondent Name**
XL Insurance America, Inc.

**MFDR Tracking Number**
M4-17-0229-01

**Carrier's Austin Representative**
Box Number 19

**MFDR Date Received**
September 29, 2016

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "MMI = $350.00
IR – W/ROM = $300.00
TTL = $650.00"

**Amount in Dispute:** $150.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The requestor's agent, Exam Works is alleging additional reimbursement in the amount of $150.00 is warranted based on a full examination with range of motion. However, per the designated doctor report dated 02/23/16, Mark Hanson, DC found after considering all differentiators, the examinee's subjective symptoms and the medical records, that the examinee's injury was best rated under Table 72 Lumbosacral DRE (Diagnosis Related Estimate) Category II, for 5% whole impairment of the lumbar spine. Therefore, pursuant to division rule §134.204(j)(4)(i-iii) the maximum allowable reimbursement (MAR) for musculoskeletal body areas is $150.00 for each body area rated based on the DRE method. Per the CMS-1500 billing form only the spine area was rated."

**Response Submitted by:** CorVel

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| February 23, 2016 | Designated Doctor Examination | $150.00 | $150.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' Compensation State Fee Schedule Adj

**Issues**

1. What is the maximum allowable reimbursement (MAR) for the disputed services?
2. Is the requestor entitled to additional reimbursement?

**Findings**

1. Per 28 Texas Administrative Code §134.204(j)(3), "The following applies for billing and reimbursement of an MMI evaluation… (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." The submitted documentation supports that the requestor performed an evaluation of Maximum Medical Improvement. Therefore, the correct MAR for this examination is $350.00.

   Per 28 Texas Administrative Code §134.204(j)(4),

   > The following applies for billing and reimbursement of an IR evaluation.
   > (A) The HCP shall include billing components of the IR evaluation with the applicable MMI evaluation CPT code. The number of body areas rated shall be indicated in the units column of the billing form.
   > (B) …
   > (C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas.
   > (i) Musculoskeletal body areas are defined as follows:
   > (I) spine and pelvis;
   > (II) upper extremities and hands; and,
   > (III) lower extremities (including feet).
   > (ii) The MAR for musculoskeletal body areas shall be as follows.
   > (I) $150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used.
   > (II) If full physical evaluation, with range of motion, is **performed** [emphasis added]:
   > (-a-) $300 for the first musculoskeletal body area; and
   > (-b-) $150 for each additional musculoskeletal body area.

   The submitted documentation supports that the requestor provided an impairment rating for the spine and performed a full physical evaluation with range of motion. Therefore, the correct MAR for this examination is $300.00.

2. The total MAR for the disputed services is $650.00. The insurance carrier paid $500.00. An additional reimbursement of $150.00 is recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $150.00.

***ORDER***

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $150.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

| | Laurie Garnes | October 31, 2016 |
|---|---|---|
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.